Attachment I

Tax Treatment of Long-Term Care Expenses & Long-Term Care Insurance

Health Insurance Portability & Accountability Act of 1996
(Public Law 104-191, 110 Statutes 1936, 2054 & 2063)

Federal & state tax codes have a purpose beyond raising revenue. Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The 1996 Health Insurance Portability & Accountability Act (HIPAA – Public Law 104-191, 110 Stat. 1936, 2054 & 2063) is one of the most far-reaching laws passed by Congress in the latter part of the 20th century. The effects of HIPAA are so complex that federal and state governments continue to grapple with its legislative intent.

HIPAA's impact on the treatment of long-term care expenses and long-term care insurance is the focus of this section. Congress attempted to fulfill a number of different public policy objectives in taking on long-term care as a topic: (1) classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief; (2) categorizing long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and (3) providing the general public an incentive to purchase long-term care insurance.

The general categories in this section include:

- *Tax treatment of long-term care expenses*
- *Definition of a "chronically ill" individual*
- *General tax treatment of TQ & NTQ long-term care insurance*
- *Tax qualified long-term care insurance deductibility*
- *Current efforts to expand tax incentives for long-term care expenses and long-term care insurance*

Tax Treatment of Long-Term Care Expenses

The Internal Revenue Code allows deductions for medical and dental expenses t under certain circumstances (IRC Sec. 213d). Prior to the passage of HIPAA, a broad range of long-term care expenses were generally not deductible. Part of Congress' intent in enacting HIPAA was to provide tax relief to individuals and families that were incurring long-term care costs. However, part of the challenge facing legislators was determining which expenses would qualify.

The broad and expanding nature of long-term care expenses made it difficult to stipulate a "laundry list" of qualified services. The IRS defines "qualified long-term care services" as:

> *Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner*

This overly broad universe of services could potentially be used by anyone at any time for services normally covered under healthcare insurance. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a *chronically ill individual*.

- A chronically ill individual must be certified by a licensed health care practitioner within the previous 12 months as one of the following:

    1. *The insured is unable, for at least 90 days, to perform at least two activities of daily living (ADL's) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. (See IRS Notice 97-31, issued May 6, 1997 or CIC 10232.8(e1 – 6) for the definitions of the ADL's.)*
    2. *The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.*

This standardized definition of a chronically ill person cannot be altered in any way by state law, and it is the only definition allowed to receive the favorable tax treatment for the cost of long-term care services.

Licensed Health Care Practitioner

The Internal Revenue Service defines the licensed health care practitioner (LHP) in very general terms. They can include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. California Insurance Code Section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and "shall not be compensated in any manner that is linked to the outcome of the certification" (CIC 10232.8(c). Federal and State law requires the certification of the insured's assessment be renewed annually.

90-Day Certification for Activities of Daily Living

This component of the long-term care qualification may be the most misunderstood. A review of its impact as it applies to long-term care insurance is addressed later in this section. Its relevance to the deductibility of long-term care expenses is clear. Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it would have had the unintended consequence of allowing taxpayers to deduct all their expenses associated with short-term disabilities, due to the vague nature of the definition of a qualified *long-term care service*.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition, must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be recertified at least annually.

Note: IRS Publication 502 stipulates that the 90 day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay

benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

Substantial Assistance

For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both *hands-on assistance* and *standby assistance*.

- **Hands-On Assistance:** means the physical assistance of another person without which the individual would be unable to perform the ADL.
- **Stand-By Assistance:** means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

Severe Cognitive Impairment & Substantial Supervision

Notice 97-31 defines a *severe cognitive impairment* "as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning." The 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be recertified every 12 months to ensure that they still qualify for benefits.

Note: Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

Tax Qualified Long-Term Care Insurance

The Federal and state governments have recognized the impact of long-term care expenses on their state Medicaid budgets. Over the last 40 years the Medicaid (called Medi-Cal in California) program has become the primary source for long-term care expenses in the United States for the middle class population. Congress is attempting to shift the Medicaid burden to the private sector by providing general tax incentives to purchase long-term care insurance in anticipation of the huge number of baby boomers who may need care in the future.

Prior to HIPAA, neither long-term care insurance premiums or benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as (accident & health or disability) for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free. This was pre-HIPAA a rule of thumb for all insurance.

HIPAA stipulates that generally, long-term care insurance policies that use the definition of a chronically ill individual will be "qualified long-term care insurance" and that long-term care expenses incurred by a taxpayer who qualifies as a chronically ill individual will be deductible as a medical expense (HIPAA also requires certain consumer protection provisions that will be discussed later).

- *Tax qualified long-term care insurance is treated the same as an accident & health insurance policy*
- *Benefits pass tax-free*
  1. *Per diem and cash method policy benefits received are subject to an annually adjusted amount -- $220/day in 2003 (indexed upwards annually by approximately 5%.*
- *Premiums are generally deductible*
  1. *Limits apply to individuals, sole proprietors, owners of S-corporations, & LLP's*
  2. *Premiums paid by an employer for an employee are 100% deductible*
  3. *Not counted as income to an employee*
  4. *Cannot currently include qualified long-term care insurance in a Section 125 Cafeteria plan or flexible spending arrangement*

Various deductibility scenarios will be explored later in this section.

Congress created a generalized structure to which qualified products must adhere. For purposes of HIPAA, a qualified long-term care insurance product must pay benefits using no less than 5 or no more than 6 of the following activities of daily living:

- *Eating*
- *Toileting*
- *Transferring*
- *Bathing*
- *Dressing*
- *Continence*

Note: Qualified long-term care insurance policies may not use "medical necessity" as a benefit trigger and must coordinate benefit payment with Medicare.

This 5 – 6 ADL structure created concern in California because policies issued in California after January 1, 1993, that provided benefits for home care services, were required to use a benefit trigger of 7 ADL's; the six listed above plus ambulating. Generally, all qualified long-term care insurance policies issued nationwide utilize a 6 ADL structure requiring a loss of 2 or 3 ADL's to qualify for benefits (subject to certification by a LHP that the impairment is likely to last for at least 90 days).

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of State Senate Bill 1943, including:

- *Guaranteed renewability or noncancellability*
- *Prohibitions on exclusions and limitations*
- *Provisions relating to extension of benefits & conversions*
- *Replacement*
- *Unintentional lapse*
- *Post-claim underwriting*
- *Requirement to offer inflation protection & rejection by consumer*
- *Restrictions on preexisting conditions and probationary periods*
- *Disclosure*
- *Non-forfeiture provisions*

HIPAA requires that long-term care insurance policies comply with its guidelines to be considered "qualified" long-term care insurance. Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance. However, HIPAA was silent as to the tax treatment of benefits received from non-qualified policies issued after January 1, 1997 causing confusion. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

HIPAA also establishes a reporting mechanism for benefits received under <u>*all*</u> long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an IRS 1099 LTC Form issued by the

carrier. Benefits reported on the 1099 must also be reported on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does not need to determine the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional mystery to the taxation of non-qualified benefits conundrum because it provides a vehicle for these benefits to be taxed. Despite continuing confusion neither the Department of the Treasury nor Congress seems anxious to clarify this matter.

Long-term care insurance benefits that are part of a life insurance or annuity contract may not receive the same tax favored status as benefits received from a tax qualified long-term care insurance policy. If the benefits constitute an advance payment of death benefit, then it is likely that they will not be taxed as income. If, however, the benefits received are part of the accumulation value of the contract, taxes may be payable. In no case are the premiums paid for life insurance or annuity contracts, which include long-term care insurance benefits, deductible as tax qualified long-term care insurance premiums.

Grandfathered Long-Term Care Insurance Policies

Congress realized that there were many long-term care insurance policies issued prior to January 1, 1997, that would not comply with HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for "grandfathered" policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting "long-term care insurance requirements of the State in which the contract was … issued" would be grandfathered for the purposes of tax qualification unless the policyholder made a "material change" to the policy. However, they did not define material change.

Final regulations issued in December 1998 identified criteria for which a material modification that would result in a policy losing its tax qualified status. Action that could be

taken by the policyholder that is not material and *would not* jeopardize the policy's grandfathered status includes the following:

- *A change in the mode of premium payment*
- *A classwide increase or decrease in premiums for contracts that have been issued on a guaranteed renewable basis*
- *A reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family*
- *A reduction in coverage (with correspondingly lower premium) made at the request of a policyholder*
- *A reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status)*
- *The addition without an increase in premiums of alternative forms of benefits that may be selected by the policyholder*
- *The addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract*
- *The deletion of a rider or provision of a contract (called an HHS – Health & Human Services – rider) that prohibited coordination of benefits with Medicare*
- *The effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract*
- *The substitution of one insurer for another in an assumption reinsurance transaction*
- *Expansion of coverage under a group contract caused by corporate merger or acquisition*
- *Extension of coverage to collectively bargained employees*
- *The addition of former employees*

The Final Regulations suggest that the following practices will be treated as issuance of a new contract:

- *A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company*
- *A substitution of the insured under an individual contract*
- *A change (other than an immaterial change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract*

Note: The important message that should be grasped from this review is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised. A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90 day

certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for care.

Tax Qualified Long-Term Care Insurance Premium Deductibility

The Health Insurance Portability & Accountability Act of 1996 and subsequent Department of the Treasury rulings have created a number of different premium deduction scenarios that benefit consumers. The tax incentives that allow for premium deductibility help the self-employed and employees of companies that provide employer-paid long-term care insurance. To a lesser extent, some individual taxpayers, who are not self-employed, will benefit from the premium deductibility allowed by HIPAA.

There are four primary deductibility scenarios for tax qualified long-term care insurance. They are:

- *Medical Savings Accounts*
- *Individual deductibility*
- *Deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) & limited liability corporations (LLC)*
- *Deductibility for employee/owners of C-corporations*

The intent of this next section is to provide students with broad-brush guidance pertaining to the tax deductibility of TQ long-term care insurance premiums. Most agents are not Certified Public Accountants (CPA's) or tax preparers. They should always refer clients to insured's tax advisor for the final analysis as to whether premium deductibility makes sense for them.

Medical Savings Accounts

Medical Savings Accounts (MSA) were established under HIPAA. Their primary appeal is to consumers under age 65, who are willing to take on the responsibility of a relatively large medical insurance deductible in favor of lower premiums. Simply stated, the consumer purchases a medical insurance plan with a high deductible that generally exceeds $4,000. They are then allowed to take an above-the-line deduction on their taxes equal to a percentage of the deductible (65% for an individual, 75% for a couple or family). The amount of money deducted must be placed in an MSA account. The money placed in the MSA grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for unreimbursed medical expense (allowed by IRC Sec. 213(d)) deductibles and

co-insurance. *The money in the MSA can also be used to pay the premiums on a tax qualified long-term care insurance policy.* From a practical standpoint, this is the only way an individual, self-employed or otherwise, can garner the equivalent of an above-the-line deduction for a qualified long-term care insurance policy.

MSAs have achieved inconsistent acceptance since their introduction in 1997. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional "low-deductible" plans and the "high-deductible" plans that qualify for the MSA program. MSAs represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

Individual Deductibility

This deductibility scenario for tax-qualified long-term care insurance is one of the most misunderstood applications. It is true that only taxpayers who itemize their deductions can benefit from the deductibility of qualified long-term care insurance premiums. It is also a fact that, based on the taxpayer's age, only a portion of the long-term care insurance premium may be deducted. With this in mind, taxpayers and their advisors may be wise to step back and take a broader view of the opportunities.

Taxpayers over age 60 with above average income and assets are typically interested in long-term care insurance. Often these individuals do itemize their deductions because they own property and the standard deduction is not in their best interest. In this situation, expenses for medical care and insurance premiums are deductible to the extent that they exceed 7.5% of adjusted gross income. Prior to HIPAA, most taxpayers in this circumstance would not exceed 7.5% of their adjusted gross income in unreimbursed medical expenses. However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy. *However, unlike other accident and health insurance*

premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted. In 2003, the age that "banded" amounts that may be applied towards the taxpayer's un-reimbursed medical expenses are:

- **Under Age 40** **$ 250**
- **Ages 41 - 50** **$ 470**
- **Ages 51 - 60** **$ 940**
- **Ages 61 - 70** **$2,510**
- **Ages 71 +** **$3,130**

Note: These amounts allowable towards deductions are indexed upward annually by a factor of approximately 5%.

Individual taxpayers under age 61 who itemize their deductions, may not get much of a tax relief by including the allowable long-term care insurance premium amount in their unreimbursed medical expenses. However, someone age 61+ may do better. To reiterate, individual taxpayers who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The amount allowed is limited by the above-referenced, age-related amounts. The following is a *thumbnail* example of how this may work for a hypothetical husband and wife, both age 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of $7,000. Assume, for the purposes of this example, that this couple has an adjusted gross income of $100,000 therefore they must exceed $7,500 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

- Amount Allowed For TQ-LTCi: $5,020
- Medicare Supplement Premiums 3,600
- Medicare Part B Premiums 1,400
- Other Allowable Medical Expenses (Rx, eyeglasses, dental) 2,000
  - ***Total*** ***$12,020***

In this example, the taxpayers would be allowed to deduct $4,520 ($12,020 minus their $7,500 threshold) of un-reimbursed medical expenses. If they are in a combined federal *and* state income tax bracket of 35%, their tax savings would equal $1,582 ($4,520 x 35%). This would amount to a 22% premiums savings ($1,520 ÷ $7,000). *Clearly, anyone can create an example that works!* But consider the facts in this case. The deductible amount allowed for long-term care insurance premiums in and of itself is not enough to trigger a deduction for

these taxpayers, nor are the stand-alone deductions for the other unreimbursed medical expenses. *However, the combination of all of them does provide this hypothetical couple with a meaningful savings.* Most agents are not qualified tax advisors and as such need to be cautious and circumspect in their recommendations. However, an agent may spot an opportunity for a taxpayer that might go unnoticed by the client's tax preparer. Clearly, if the agent inquires as to the unreimbursed expenses illustrated above they can spot a potential tax savings for the consumer and refer them to their tax advisor.

Deductibility for the Self-Employed

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships ("LLP") and limited liability corporations ("LLC"). An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only. The profit or loss from the business entity is passed through to the owners pursuant to their share of ownership. Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees. Spouses of owners of S-corporations, LLP's and LLC's are considered owners regardless of their direct or indirect participation in the business' activities. *With respect to accident and health insurance coverage purchased by one of these entities for a non-owner-employee, premiums are fully deductible, there is no imputed income to employee of premiums and the benefits pass tax free at time of claim.*

The good news for owners of these entities is that beginning in 2003 premiums for accident and health insurance are 100% deductible. It is not necessary for these taxpayers to exceed 7.5% of adjusted gross income to benefit from the tax code for these expenses. Tax qualified long-term care insurance, being accident and health insurance, falls into this general rule. The bad news is that the amount allowable for deduction is limited by the previously discussed age-related schedule.

While this is not optimal, it can lead to savings. Consider a self-employed husband and wife, both age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of $3,600 per year. They would be allowed to deduct $1,880 ($940 x 2). If they are in the combined Federal & State tax bracket of 35% their tax savings would be $658 or approximately 18% of premium. Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 16% of the premium paid. Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses. *Agents should be very cautious and understand their limitations of advising consumers about their insured's specific tax situation and circumstances.*

Deductibility in Closely-Held C-Corporations

The fine difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners. Therefore, premiums paid by the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees is deductible to the corporation: there is no imputed income to the employee stockholder for premiums paid; and the benefits will pass tax-free at time of claim. Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive "like" benefits. Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits. Both are incorrect.

The Internal Revenue Code Sec. 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable *class of employees* who are eligible for the benefit, is not allowed. The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as "officer employees" can be created for the corporation who are eligible for a specific accident and health insurance benefit. However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and their tax advisors to be judicious in establishing classes eligible for coverage. It is also important for the corporation to establish the plan in their minutes and to clearly identify the classes of employees that are eligible for benefits.

Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation; there is no income imputed to the employee and the benefits pass tax free at time of claim. This tax scenario is the best of all worlds for employees of any corporation and owner-employees of closely-held C-corporations.

Final Items On Tax Deductibility

Currently long-term care insurance *may not* be included in Section 125 Cafeteria Plans or Flexible Spending arrangements. However, for the past several sessions of Congress, legislation has been introduced to allow for this. Additionally, this legislation has attempted to expand individual deductibility and create tax credits for taxpayers who incur long-term care expenses. Over the years there has also been legislation in California designed to expand premium deductibility for State income tax purposes and to provide credits for long-term care expenses. While this paper will not speculate on the outcome of these efforts to provide additional incentives to purchase qualified long-term care insurance, legislators appear to see private insurance as an important tool of public policy.